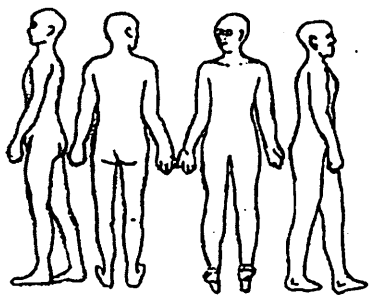
Patient's Condition Description / Health History

Patient Name: _____ **Date:** _____



Mark your problem areas on the diagram

Rate your pain level

Stiff 1 2 3 4 5 6 7 8 9 10 Numb

What helps _____

Makes it worse _____

Activities affected _____

_____

Date of Onset	
Is this accident related If YES how and when	
Main Complaint	
Describe Symptoms	
Pain Frequency & Quality	constant, comes and goes, occasional, ache, burn, sharp, with movement
Treatments you have tried	
Imaging done and date	x-ray / MRI / CT
Treatment Goals (ie: pain relief, increase range of motion, sleep, sit, drive, exercise, work)	

DETAILED HEALTH HISTORY - CHECK ALL THAT APPLY -use back if needed

Musculoskeletal
- o Low back pain
- o Mid back pain
- o Pain between shoulders
- o Neck pain
- o Arm pain L/R
- o Leg pain L/R
- o Swollen joints
- o Painful joints
- o Stiff joints
- o Muscle Spasms
- o Muscle weakness
- o Shoulder pain L/R
- o TMJ / Jaw problems

Lifestyle
- o Smoke
- o Alcohol _____

Nervous System
- o Numbness
- o Loss of feeling
- o Paralysis
- o Dizziness
- o Fainting
- o Headaches
- o Muscle jerking
- o Seizures
- o Loss of coordination
- o Eye problems
- o Forgetfulness
- o Confusion
- o Clinical depression
- o Chronic insomnia

Cardio-Vascular
- o Chest pain
- o Pain over heart
- o Difficulty breathing
- o Persistent cough
- o Rapid heartbeat
- o Blood pressure problems
- o Heart problems
- o Lung problems
- o Varicose veins
- o PACEMAKER

Genito-Urinary System
- o Bladder trouble
- o Excessive urination
- o Scanty urination
- o Painful urination

Gastro-Intestinal
- o Poor appetite
- o Excessive hunger
- o Difficulty chewing
- o Difficulty swallowing
- o Excessive thirst
- o Nausea
- o Vomiting
- o Abdominal pain
- o Diarrhea
- o Constipation
- o Black stool
- o Bloody stool
- o Liver trouble
- o Gall bladder problems

Other condition not listed:

Are you currently being treated for any of the following conditions

o AIDS	o Tumors	o Osteoporosis	o Heart disease
o Cancer	o Diabetes	o Scoliosis	o Heart attack/stroke
o Polio	o Arthritis	o Multiple sclerosis	o Vascular disease
o Other			o High blood pressure

Are you or could you be pregnant? YES / NO **Do you have a history of Kidney stones or Gall stones?** YES / NO

HAVE YOU HAD BACK SURGERY and do you have plates, rods or screws? _____

Recent or MAJOR SURGERIES: _____

List all l the MEDICATIONS you are taking: _____